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No. 89-939

In The

Supreme Court of the United States

October Term, 1989

HEALTHAMERICA AND PAMELA MERLE,

Petitioners,

v.

EDWARD MENTON,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF ALABAMA

REPLY MEMORANDUM

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REPLY MEMORANDUM

I. MENTON'S COMMON LAW FRAUD CLAIM IS PREEMPTED AND THE OPINION OF THE ALABAMA COURT IS IN DIRECT CONFLICT WITH FEDERAL APPELLATE DECISIONS

Menton conceded that the decisions of the Ninth and Eleventh Circuits, in *Farlow v. Union Central Life Ins. Co.*, 874 F.2d 791 (11th Cir. 1989) and *Davidian v. Southern California Meatcutter's Union*, 859 F.2d 134 (9th Cir. 1988), directly conflict with the holding of the Alabama Supreme Court that his common law fraud claim is not preempted.[1] This direct conflict must be resolved.

Menton argues that the recent opinion of the Fifth Circuit in *Wells v. General Motors Corporation*, 881 F.2d 166 (5th Cir. 1989), supports the opinion of the Alabama Supreme Court. Contrary to Menton's analysis, the Court merely held that the employer's Voluntary Termination of Employment Plan, offering severance payments, was not an ERISA "employee benefit plan" and, therefore, ERISA preemption was not applicable. The Fifth Circuit has not changed its

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[1] Menton insinuates that the eleventh Circuit decision in *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277 (11th Cir. 1987), does not directly conflict with the opinion of the Alabama Supreme Court. (Opp. at 12, n4). However, Menton is careful not to deny that the amended complaint in *Belasco* (which was presented to the Alabama Supreme Court, Pet. App. at 33a) included a claim for fraudulent inducement virtually identical to Menton's claim: the plaintiffs in *Belasco* alleged they were induced into purchasing dependent protection under an ERISA governed plan and, also in reliance upon representations regarding coverage under the plan, into *discontinuing* their dependent coverage under an *existing policy* of insurance. (Para. 15-22 of the amended complaint, submitted to the Supreme Court of Alabama with the May 19, 1989, letter brief of the Appellants). Thus, the Eleventh Circuit has consistently held that Alabama fraud claims based upon representations concerning coverage available under an ERISA benefit plan, including claims that the employee dropped existing coverage and switched to a different coverage in reliance, "relate to" the administration of the welfare plan and are preempted.

holding in *Hermann Hospital v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir. 1988), where it ruled that a fraud claim by even a non-participant (a healthcare provider) based upon representations that an individual was covered under the plan "related to" the plan and was preempted. *Id.* at 1290. Petitioners respectfully suggest that in the Fifth Circuit a fraud claim like Menton's, based upon representations concerning benefits available under the plan, is preempted on authority of *Hermann Hospital. See also Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290 (5th Cir. 1989).

Menton also argues that the Petitioners were not "explaining coverages and options" within the Press Register's benefit plan. (Opp. at 10). To this contention, Petitioners would direct the court's attention to the facts as outlined in their Petition to this court and in Menton's Opposition. Clearly, Menton's fraud claim arose out of and "relates to" the administration of the Press Register's welfare benefit plan.[2]

It is undisputed that Menton was already a participant in the Press Register's welfare benefit plan when he selected one of the "alternative medical benefit selections" offered by the Press Register in the spring of 1985. Menton selected the HealthAmerica alternative because of Merle's incorrect answer to his specific coverage question at a meeting held for Press Register employees during which they could ask coverage questions about the three "medical benefit selections" that comprised the benefit plan. By contract entered on May 15, 1985, HealthAmerica became part of the Press Register's plan (one of the "alternative medical benefit selections") over a month before the June 17 meeting when Menton asked his

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[2] Further, as was aptly pointed out in the Brief Amici Curiae for American Counsel of Life Insurance and the Health Insurance Association of America, at p.5, Menton contended in his fraud claim that HealthAmerica "denied coverage and refused to pay for" his son's physical therapy and "refused to pay" for certain medical appliances. Clearly, Menton's claim is based not only on his dropping of Connecticut General coverage but also upon HealthAmerica's denial and refusal to pay his claim for benefits. It is axiomatic that a claim for the denial or refusal to pay benefits "relates to" the plan.

coverage question. It is undisputed that Menton was a participant in his employer's existing benefit plan when he elected to switch to another "medical benefit selection" or option within that same plan. Under the applicable authorities, the ERISA governed welfare plan was the benefit package (including the alternate medical benefit selections) offered by Menton's employer. Accordingly, Menton's attempt to distinguish the cases relied upon by Petitioners as involving representations made *after* the employee became a participant in the ERISA plan is without merit.[3]

At the very least, the opinion of the majority of the Supreme Court of Alabama with regard to Menton's common law fraud claim (the only claim presented to the jury) directly conflicts with the decisions of the eleventh and Ninth Circuits. Petitioners suggest that it is also in conflict with the decisions of the Fifth Circuit, the ERISA preemption analysis of this court in *Pilot Life*, and the other authorities relied upon by Petitioners. Review by this Court is necessary to resolve these conflicts.

II. WHETHER MENTON'S CLAIM UNDER ALABAMA'S TWISTING STATUTE IS "SAVED" FROM ERISA PREEMPTION

Menton argues that Alabama's twisting statute "saves" his claim from ERISA preemption because it is a law which "regulates insurance." Menton cites, for the first time, certain cases applying the McCarran-Ferguson Act in connection with the advertising and sale of *insurance policies* by

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[3] Menton, also argues that his claim "concerns the destruction of his old plan," because he was induced to "drop" his existing Connecticut General Health Insurance. If his claim is based on the "destruction" or dropping of his Connecticut General Insurance (provided through an existing ERISA governed welfare benefit plan) in favor of an "alternative medical benefit selection" within the same welfare benefit plan, such a claim surely "relates to" the benefit plan.

insurance companies.[4] None of these authorities were cited to or considered by the Alabama Courts. For several different reasons, Menton's argument and newly cited authorities provide further reason for this Court to grant review in this case.

HealthAmerica is a health maintenance organization and did not issue or sell any policy of insurance. Accordingly, the cases relied upon by Menton simply do not apply to the activities of HealthAmerica. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979). Menton's argument that the activities of HMOs *should be* subject to state insurance regulation is without support in the decisions of this Court.[5]

The authorities relied upon by Menton, including *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), predate *Pilot Life*. Accordingly, they do not consider what this court considered most significant, i.e., the relationship between the application of the specific state law and the role of the savings clause in ERISA in light of ERISA's exclusive civil enforcement scheme. Menton's authorities do not consider the effect of allowing punitive awards under the different states' trade practices acts for conduct which "relates to" the benefit plan and which is specifically

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[4] *FTC v. National Cas. Co.*, 357 U.S. 560 (1958); *Dexter v. Equitable Life Assurance Society of the United States*, 527 F.2d 233 (2nd Cir. 1975); *Seasongood v. K & K Insurance Agency*, 414 F.Supp. 698 (E.D.Miss. 1976), *rev'd on other grounds*, 548 F.2d 729 (8th Cir. 1977).

[5] Menton's argument that HMOs are regarded as a form of insurance in Alabama, according to the provisions of the Alabama HMO Act (*Ala. Code*, §§27-21a-1 through 27-21a-32) is shocking. Menton has previously conceded that Alabama's HMO provisions (including §27-21a-13b and §27-21a-1) have no application in this lawsuit because the HMO statute did not become effective until *after* Menton's claims accrued and the HMO statute could not be given retrospective effect. (Appellee's Brief, p.62, filed January 13, 1989). If the twisting statute is to be saved from ERISA preemption as a law regulating insurance, it must do so without any reference to or assistance from Alabama's HMO statute.

regulated by ERISA, e.g., information disclosure.[6] A state law which allows the award of punitive damages against an ERISA administrator of fiduciary, *even if* the law satisfies the McCarran-Ferguson Act factors, is preempted because Congress intended ERISA's civil enforcement mechanism to be exclusive of other remedies. *Pilot Life; Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96 (9th Cir. 1988), *cert denied*, 109 S.Ct. 3216 (1989); *Commercial Life Insurance Company v. Juliano*, 764 P.2d 1059 (Cal. 1988), *cert denied*, 109 S.Ct. 2087 (1989).

While the dicta from *Metropolitan Life Ins. Co. v. Massachusetts* relied upon by Menton and his McCarran-Ferguson Act cases appear to support the proposition that the sale and advertising of insurance by insurance companies is subject to state insurance regulation, Petitioners contend that the following authorities directly support their position that Menton's claim for damages under the twisting provision in the Trade Practices Act is not "saved" from ERISA preemption as a law that "regulates insurance". *Pilot Life; Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988); *Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96 (9th Cir. 1988), *cert denied*, 109 S.Ct. 3216 (1989); *Powell v. Chesapeake & Potomac Telephone Co. of Virginia*, 780 F.2d 419 (4th Cir. 1985), *cert denied*, 476 U.S. 1170 (1986); *Keel v. Group Hospitalization Medical Services, Inc.*, 695 F.Supp. 223 (E.D.Va. 1988); *Dennette v. Life of Indiana Insurance Company*, 693 F.Supp. 959 (D.Co. 1988); *Rollo v. Maxi-Care of Louisiana, Inc.*, 695 F.Supp. 245 (E.D.La. 1988). The decision of the Alabama Supreme Court is in conflict with *Pilot Life* and these authorities on the application of ERISA's insurance savings clause.

There is an additional reason why Menton's claims are not "saved" from ERISA preemption by the twisting statute.

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[6] The circuits have held that conduct which "relates to" a plan cannot provide the basis for a claim for punitive damages regardless of whether the claim is denominated in state law or under ERISA. *Amos v. Blue Cross-Blue Shield of Alabama*, 868 F.2d 430, 431 n.2 (11th Cir.), *cert denied*, 110 S.Ct. 158 (1989).

Although Menton pled only a common law fraud claim against the Petitioners, Menton actually tried the case as a "bad faith" claim against an insurance company for the wrongful denial of a claim for benefits.[7] In reality, the verdict and punitive award in this case are based on that portion of Menton's claim dealing with HealthAmerica's denial and refusal to pay his claim. Such claims are undisputedly related to the administration of the claim and are not "saved" from ERISA preemption. *Pilot Life*. The cleverness of counsel in pleading only a one count common law fraud claim but actually trying a bad faith denial of benefits claim should not allow Menton to subvert the intent of Congress.

Finally, Menton is silent as to the recent holding of the Third Circuit in *FMC Corp. v. Holliday*, 885 F.2d 79, 90 (3rd Cir. 1989), that the "deemer" clause requires the preemption of any "state insurance regulation [that] intentionally or unintentionally addresses a core type of ERISA matter which Congress sought to protect by the preemption provision." The

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[7] Petitioners raised, as a separate issue on appeal (VI), the denial of their objections and motion for mistrial based upon the improper argument of Menton's counsel which focused the jury's attention on the fact that HealthAmerica decided to deny Menton's claim for extended rehabilitation benefits even though HealthAmerica was aware that Merle might have given Menton the wrong information and HealthAmerica was aware of the need of Menton's son for rehabilitation ("this child's medical condition"). (RT at 261-264). The trial court denied Petitioners' objections and motion for mistrial which was based on Menton's counsel's deliberate efforts to distract the jury's attention away from the facts pertaining to his fraud claim and onto HealthAmerica's *subsequent* conduct in handling and denying Respondent's claim. The Alabama Supreme Court did not directly address this issue in its opinion. (Pet. App. 20a-21a). An honest and fair review of the record reveals that the excessive punitive award was the direct result of the success of Plaintiff's counsel in focusing the jury's attention on HealthAmerica's conduct in the processing and denial of Menton's claim for benefits and was not the result of Merle's mistake in answering Menton's coverage question. *The jury's verdict was based on HealthAmerica's post-representation conduct and the denial of Menton's claim for extended benefits* – all of which is totally irrelevant to a fraud in the inducement claim.

Court held that, even with regard to "insured" plans, "the deemer clause guards against any insurance regulation that infringes on such ERISA areas as reporting, disclosure and nonforfeitability." *Id.* at 88. Since the application of Alabama's twisting statute in this case directly infringes on the ERISA information disclosure and fiduciary standards regulated by Congress, the deemer clause applies and the twisting statue is not "saved" *even if* it "regulates insurance." This conflict also requires resolution.

III. ERISA'S INFORMATION DISCLOSURE REQUIREMENTS, FIDUCIARY STANDARDS, AND CIVIL ENFORCEMENT SCHEME

Menton argues that the Petitioners failed to raise ERISA's disclosure and fiduciary provisions in the Alabama courts. Menton was the Plaintiff and chose not to claim his ERISA remedies in the trial court. (Pet. App. at 3a). Thus, Petitioners were under no duty to either defend against such claims or to prove Menton's potential ERISA claims. The existence of a federal remedy is not a prerequisite to federal preemption under ERISA. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Lister v. Stark*, 890 F.2d 941, 946 (7th Cir. 1989).

In briefs to the Alabama Supreme Court and at oral argument Menton argued that his claims were not preempted because he would have no remedy under ERISA's civil enforcement scheme.[8] The Petitioners answered this argument, in their Reply Brief and subsequent letter briefs, by pointing out the following: ERISA imposed certain information disclosure requirements on the Press Register as the plan "administrator"; ERISA imposed certain obligations on HealthAmerica as a "fiduciary" under the plan; the disclosure of information to participants about options and coverages is

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[8] The Alabama Supreme Court appears to have adopted Menton's argument that ERISA preemption of state law cannot be applied where there is no federal ERISA remedy. (Pet. App. at 19a). This aspect of the Alabama court's opinion is further grounds for review.

part of the administration of the plan; HealthAmerica may be liable under ERISA for breach of fiduciary duty; the Press Register's failure to satisfy ERISA's disclosure requirements (e.g., making a complete copy of the plan available in the office of the administrator) combined with Merle's incorrect answer might give Menton a claim under 29 U.S.C. § 1132(a) for recovery of the benefit denied, i.e., extended rehabilitation benefits; *et al.* Despite this, the Alabama Supreme Court concluded that Menton had no remedy under ERISA. (Pet. App. 19a).

The record on appeal includes the documents governing the HealthAmerica option within the Press Register's benefit plan and the evidence which establishes that HealthAmerica was an ERISA fiduciary and that the Press Register was the plan "administrator." Petitioners have outlined how Congress regulated the areas of information disclosure and fiduciary responsibilities and provided exclusive enforcement mechanisms. (Pet. 13-17). This court should not refuse to review this case or address these areas because of Menton's failure to plead and prove his ERISA claims in the courts below.

IV. PUNITIVE DAMAGES AND DUE PROCESS

Menton argues that Petitioners' due process challenges to the punitive award were not timely raised. However, the trial court specifically addressed Petitioners' constitutional objections, and Petitioners would direct the Court's attention to the Amici Curiae Brief of the Alabama Defense Lawyers Association, at 7-10, where it is clearly demonstrated that Petitioners' due process challenges are preserved for review.

Menton also argues that Petitioners were provided due process of law under "recently augmented" standards and procedures. However, the authorities relied upon by Menton to support this contention are almost all "post-*Menton*" and were applied by neither the trial court nor the Supreme Court of Alabama to this excessive punitive award.[9] Finally,

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[9] *See Central Alabama Elec. Coop. v. Tapley*, 546 So. 2d 371 (Ala. 1989); *Green Oil v. Hornsby*, 539 So. 2d 218 (Ala. 1989).

Respondent's statement that Petitioners were given "de novo" review of the trial court's damage award is untrue. Such a review (if it exists at all) is one of the "recently augmented" standards and procedures adopted by the Alabama Supreme Court as a response to the constitutional challenges raised in this and other recent cases. It was not applied to this case.

V. FACTS

The Respondent's ("Menton's") Brief In Opposition, contains several incorrect factual assertions. First, Petitioners have carefully reviewed the record on appeal and cannot find any evidence to support the following statement in Menton's Opposition: "Merle also admitted to Mr. Menton that she misrepresented the coverage." (Opp. p.4). Contrary to Menton's assertion, Merle did *not* admit to Menton that she "misrepresented" the coverage. At most, Menton's testimony would support the inference that Merle admitted to Menton that she gave the wrong answer to his question and that she was unaware of the limitation on the duration of such benefits when she answered his question.[10]

"There is no evidence that Ms. Merle was aware of the limitation on physical therapy or rehabilitation benefits when she answered Respondent's question at the meeting." (Petition at p.4). Menton does not challenge this fact in his Opposition. In fact, in his Brief in the Supreme Court of Alabama, Menton

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[10] Menton similarly misconstrued the evidence in the record concerning HealthAmerica's internal investigation of Menton's claim for unlimited rehabilitation benefits: "It was later revealed that Merle had confessed making the misrepresentation during an internal investigation of Mr. Menton's claim." (Opp. p.5). Menton appears to be referring to a "Member Comment Report" on which another HealthAmerica employee wrote that "In follow-up, Pam Merle stated that she had given Mr. Menton the wrong info." (RT 204). What Menton neglected to inform this court is that the person who wrote the above note was not called to testify and the note actually recorded what Menton said he was told by Ms. Merle. (RT 107-209). Merle never "confessed" making any "misrepresentation."

conceded this very point: "As reflected by the evidence in this case, Ms. Merle was *obviously completely unaware* of the sixty day limitation contained in HealthAmerica's plan when she made the representation to Mr. Menton." (Appellee's Brief p.123) (emphasis added). Accordingly, the conduct which caused Menton to switch options (to an "alternative medical benefit selection") within the Press Register's welfare benefit plan was nothing more than a spontaneous answer to a coverage question given without knowledge or notice of a limitation on the duration of rehabilitation benefits.

CONCLUSION

The Petition for Writ of Certiorari should be granted.

Respectfully submitted,

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